FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025411

Facility Name: Mulberry Manor

Address: P.O. Box 88, (Phy Loc: 612 E. Davie) (Number) Anna (City) 62906 (Zip Code)

County: Union

Telephone Number: (618) 833-6012 **Fax #** (618) 833-4993

IDPA ID Number: 371082826001

Date of Initial License for Current Owners: 01/01/72

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Richard Stroh **Telephone Number:** (618) 833-5070

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Richard Stroh

(Title) Asst. Comptroller

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 29280

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	80	Intermediate/DD	80	29,280	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	27,605			27,605	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,605			27,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.28%

D. How many bed-hold days during this year were paid by Public Aid?
154 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Mulberry Manor # 0025411 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,449	5,128	5,606	140,183		140,183		140,183			1
2	Food Purchase		169,083		169,083		169,083		169,083			2
3	Housekeeping	60,229	19,840	2,509	82,578		82,578	416	82,994			3
4	Laundry		9,852		9,852		9,852		9,852			4
5	Heat and Other Utilities			66,459	66,459		66,459	932	67,391			5
6	Maintenance	47,625	17,904	4,828	70,357		70,357	20,210	90,567			6
7	Other (specify):*											7
8	**TOTAL General Services**	237,303	221,807	79,402	538,512		538,512	21,558	560,070			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	811,663	21,751	4,973	838,387		838,387	4,440	842,827			10
10a	Therapy		3,868	11,336	15,204		15,204		15,204			10a
11	Activities			1,082	1,082		1,082		1,082			11
12	Social Services	82,220	11,677	9,030	102,927		102,927	(10,042)	92,885			12
13	Nurse Aide Training	10,281		4,620	14,901		14,901		14,901			13
14	Program Transportation		5,694	4,810	10,504		10,504		10,504			14
15	Other (specify):*			741,616	741,616		741,616	(741,616)				15
16	**TOTAL Health Care and Programs**	904,164	42,990	784,667	1,731,821		1,731,821	(747,218)	984,603			16
	C. General Administration											
17	Administrative	135,095			135,095		135,095	23,354	158,449			17
18	Directors Fees											18
19	Professional Services			123,566	123,566		123,566	(117,634)	5,932			19
20	Dues, Fees, Subscriptions & Promotions			9,262	9,262		9,262	(3,107)	6,155			20
21	Clerical & General Office Expenses		11,262	17,027	28,289		28,289	39,153	67,442			21
22	Employee Benefits & Payroll Taxes			211,062	211,062		211,062	24,750	235,812			22
23	Inservice Training & Education			1,218	1,218		1,218		1,218			23
24	Travel and Seminar							137	137			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			15,127	15,127		15,127	850	15,977			26
27	Other (specify):*											27
28	**TOTAL General Administration**	135,095	11,262	377,262	523,619		523,619	(32,497)	491,122			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,276,562	276,059	1,241,331	2,793,952		2,793,952	(758,157)	2,035,795			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mulberry Manor #0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,040	30,040		30,040	(4,095)	25,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,887	2,887		2,887	(2,887)				32
33	Real Estate Taxes			27,107	27,107		27,107	(1,451)	25,656			33
34	Rent-Facility & Grounds			330,000	330,000		330,000	(237,607)	92,393			34
35	Rent-Equipment & Vehicles			1,801	1,801		1,801	949	2,750			35
36	Other (specify):*			98,287	98,287		98,287	(98,287)				36
37	**TOTAL Ownership**			490,122	490,122		490,122	(343,378)	146,744			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,281	169,281		169,281		169,281			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			169,281	169,281		169,281		169,281			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,276,562	276,059	1,900,734	3,453,355		3,453,355	(1,101,535)	2,351,820			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (741,616)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(49)	22		4
5	Telephone, TV & Radio in Resident Rooms	(426)	12		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,227)	30		9
10	Interest and Other Investment Income	(48)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,839)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,614)	36		18
19	Entertainment				19
20	Contributions	(2,015)	20		20
21	Owner or Key-Man Insurance	(185)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,693)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(86,795)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(16,871)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (866,378)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(235,157)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (235,157)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,101,535)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Mulberry Manor

ID# 0025411

Report Period Beginning: 1/1/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Advertising	$ (1,274)	20	1
2	Tobacco Purchases	(742)	12	2
3	Gifts Consultants	(700)	12	3
4	Gifts Residents	(724)	12	4
5	Clothing	(536)	12	5
6	Floral	(949)	12	6
7	Behavior Rewards	(5,365)	12	7
8	Entertainment	(600)	12	8
9	Other Interest	(38)	20	9
10	Cable TV Resident	(93)	20	10
11	Rental House Depreciation	(3,872)	30	11
12	Rental House R/E Taxes	(1,978)	33	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,871)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	416	0	0	0	0	0	0	0	0	0	416	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	932	0	0	0	0	0	0	0	0	0	932	5
6	Maintenance	0	3,081	17,129	0	0	0	0	0	0	0	0	20,210	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	4,429	17,129	0	0	0	0	0	0	0	0	21,558	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,440	0	0	0	0	0	0	0	0	4,440	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(10,042)	0	0	0	0	0	0	0	0	0	0	(10,042)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(741,616)	0	0	0	0	0	0	0	0	0	0	(741,616)	15
16	**TOTAL Health Care and Programs**	(751,658)	0	4,440	0	0	0	0	0	0	0	0	(747,218)	16
	C. General Administration													
17	Administrative	0	0	23,354	0	0	0	0	0	0	0	0	23,354	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,366	(120,000)	0	0	0	0	0	0	0	0	(117,634)	19
20	Fees, Subscriptions & Promotions	(3,420)	313	0	0	0	0	0	0	0	0	0	(3,107)	20
21	Clerical & General Office Expenses	0	6,083	33,070	0	0	0	0	0	0	0	0	39,153	21
22	Employee Benefits & Payroll Taxes	(49)	24,799	0	0	0	0	0	0	0	0	0	24,750	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	137	0	0	0	0	0	0	0	0	0	137	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	850	0	0	0	0	0	0	0	0	0	850	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,469)	34,548	(63,576)	0	0	0	0	0	0	0	0	(32,497)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(755,127)	38,977	(42,007)	0	0	0	0	0	0	0	0	(758,157)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Mulberry Manor** **#** **0025411** **Report Period Beginning:** **1/1/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,099)	4,004	0	0	0	0	0	0	0	0	0	(4,095)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,887)	0	0	0	0	0	0	0	0	0	0	(2,887)	32
33	Real Estate Taxes	(1,978)	527	0	0	0	0	0	0	0	0	0	(1,451)	33
34	Rent-Facility & Grounds	0	2,393	(240,000)	0	0	0	0	0	0	0	0	(237,607)	34
35	Rent-Equipment & Vehicles	0	949	0	0	0	0	0	0	0	0	0	949	35
36	Other (specify):*	(98,287)	0	0	0	0	0	0	0	0	0	0	(98,287)	36
37	**TOTAL Ownership**	(111,251)	7,873	(240,000)	0	0	0	0	0	0	0	0	(343,378)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(866,378)	46,850	(282,007)	0	0	0	0	0	0	0	0	(1,101,535)	45

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jo Ann Keller	50	Pilot House	Cairo	kel-Tech Mgmt Co.	Anna	Accting Services
James K. Keller	50	Holly Hill	Anna	JR's Centre	Anna	Day Training
		Loncoln Square	Jonesboro	ILS 1-3	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis			
		New Way	Anna			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Kel-Tech Management Co.	25.00%	$ 416	$ 416	1
2	V	5	Utilities		Kel-Tech Management Co.	25.00%	932	932	2
3	V	6	Maintenance		Kel-Tech Management Co.	25.00%	3,081	3,081	3
4	V	19	Professional Services		Kel-Tech Management Co.	25.00%	2,366	2,366	4
5	V	20	Dues, Fees, Subscrtiptions		Kel-Tech Management Co.	25.00%	313	313	5
6	V	21	Office Expenses		Kel-Tech Management Co.	25.00%	6,083	6,083	6
7	V	22	Employee Benefits		Kel-Tech Management Co.	25.00%	24,799	24,799	7
8	V	24	Seminar		Kel-Tech Management Co.	25.00%	137	137	8
9	V	26	P & C Insurance		Kel-Tech Management Co.	25.00%	850	850	9
10	V	30	Depreciation		Kel-Tech Management Co.	25.00%	4,004	4,004	10
11	V	33	Real Estate Taxes		Kel-Tech Management Co.	25.00%	527	527	11
12	V	34	Building Lease		Kel-Tech Management Co.	25.00%	2,393	2,393	12
13	V	35	Equrpment Lease		Kel-Tech Management Co.	25.00%	949	949	13
14	Total			$			$ 46,850	$ * 46,850	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing	$	kel-Tech management Co.	25.00%	$ 4,440	$ 4,440	15
16	V	17	Administration		kel-Tech management Co.	25.00%	23,354	23,354	16
17	V	21	Clerical		kel-Tech management Co.	25.00%	33,070	33,070	17
18	V	6	Maintenance		kel-Tech management Co.	25.00%	17,129	17,129	18
19	V	19	Professional Services	120,000	kel-Tech management Co.	25.00%		(120,000)	19
20	V	34	Building Lease	240,000	J & J Partners	100.00%		(240,000)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 360,000			$ 77,993	$ * (282,007)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jo Ann Keller	Owner/Administrator	Administrator	50.00	36,000	32	80.00	Admin. Wage	$ 102,304	17-1	1
2	Diana Alley	Nursing	Program/Nursing		49,846	4	10.00	Nursing Wage	15,301	10-1	2
3	Doris Davis	Activity Director	Activities			40	100.00	Activity Wage	3,721	11-1	3
4	James K.Keller	Owner	Maintenance	50.00		10	25.00	Maint. Wage	14,725	6-1	4
5											5
6	kel-Tech Mgmt Co. Allocation										6
7	James A. Keller							Admin. Wage	21,673	19-1	7
8	Don Pippins							Admin. Wage	1,681	19-1	8
9	Jacob Alley							Maint. Wage	17,129	19-1	9
10	Diana Alley							Nursing Wage	4,440	19-1	10
11											11
12											12
13								TOTAL	$ 180,974		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: kel-Tech Management Co.
Street Address: 158 E Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: ((618) 833-5070
Fax Number: ((618) 833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt. Fee Contribution	360,999	12	$ 1,250	$	120,000	$ 416	1
2	5	UTILITIES ELECT/GAS	Mgmt. Fee Contribution	360,999	12	2,488		120,000	827	2
3	5	UTILITIES WATER	Mgmt. Fee Contribution	360,999	12	315		120,000	105	3
4	6	GROUNDS MAINT	Mgmt. Fee Contribution	360,999	12	628		120,000	209	4
5	6	MAINTENANCE SUPPLIES	Mgmt. Fee Contribution	360,999	12	42		120,000	14	5
6	6	MAINTENANCE VEHICLE	Mgmt. Fee Contribution	360,999	12	830		120,000	276	6
7	6	PREVENTATIVE MAINT	Mgmt. Fee Contribution	360,999	12	103		120,000	34	7
8	6	REPAIRS BLDG	Mgmt. Fee Contribution	360,999	12	122		120,000	41	8
9	6	REPAIRS FURN/EQUIP	Mgmt. Fee Contribution	360,999	12	2,158		120,000	717	9
10	6	REPAIRS VEHICLES	Mgmt. Fee Contribution	360,999	12	1,051		120,000	349	10
11	6	TRANSPORTATION	Mgmt. Fee Contribution	360,999	12	3,314		120,000	1,102	11
12	6	PEST CONTROL	Mgmt. Fee Contribution	360,999	12	910		120,000	302	12
13	19	LEGAL & ACCOUNTING	Mgmt. Fee Contribution	360,999	12	7,117		120,000	2,366	13
14	20	ADV. HELP WANTED	Mgmt. Fee Contribution	360,999	12	336		120,000	112	14
15	20	DUES FEES SUBSCRIPTIONS	Mgmt. Fee Contribution	360,999	12	765		120,000	254	15
16	21	EDUCATIONAL SUPPLIES	Mgmt. Fee Contribution	360,999	12	24		120,000	8	16
17	21	BANK CHARGES	Mgmt. Fee Contribution	360,999	12	15		120,000	5	17
18	21	COPIER EXPENSE SUPPLIES	Mgmt. Fee Contribution	360,999	12	366		120,000	122	18
19	21	G & A MISC	Mgmt. Fee Contribution	360,999	12	231		120,000	77	19
20	21	SUPPLIES STOCK	Mgmt. Fee Contribution	360,999	12	498		120,000	166	20
21	21	G & A SUPPLIES	Mgmt. Fee Contribution	360,999	12	8,117		120,000	2,698	21
22	21	POSTAGE	Mgmt. Fee Contribution	360,999	12	3,216		120,000	1,069	22
23	21	SOFTWARE EXPENSE	Mgmt. Fee Contribution	360,999	12	1,178		120,000	392	23
24	21	TAXES & LICENSES	Mgmt. Fee Contribution	360,999	12	184		120,000	61	24
25	TOTALS					$ 35,258	$		$ 11,722	25

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: kel-Tech Management Co.
Street Address: 158 E Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: ((618) 833-5070
Fax Number: ((618) 833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	TELEPHONE	Mgmt. Fee Contribution	360,999	12	$ 2,623	$	120,000	$ 872	1
2	21	CELL PHONE EXPENSE	Mgmt. Fee Contribution	360,999	12	1,285		120,000	427	2
3	21	UTILITIES-INTERNET	Mgmt. Fee Contribution	360,999	12	562		120,000	187	3
4	22	INS EMP GROUP	Mgmt. Fee Contribution	360,999	12	47,433		120,000	15,767	4
5	22	INSURANCE W/C	Mgmt. Fee Contribution	360,999	12	7,649		120,000	2,543	5
6	22	PAYROLL TAX EXPENSE	Mgmt. Fee Contribution	360,999	12	19,521		120,000	6,489	6
7	24	ADM. STAFF TRAINING	Mgmt. Fee Contribution	360,999	12	416		120,000	138	7
8	26	INSURANCE BLDG & LIAB	Mgmt. Fee Contribution	360,999	12	1,388		120,000	461	8
9	26	INSURANCE VEHICLES	Mgmt. Fee Contribution	360,999	12	1,169		120,000	389	9
10	30	DEPRECIATION	Mgmt. Fee Contribution	360,999	12	12,046		120,000	4,004	10
11	33	REAL ESTATE TAXES	Mgmt. Fee Contribution	360,999	12	1,584		120,000	527	11
12	34	LEASE BLDG	Mgmt. Fee Contribution	360,999	12	7,200		120,000	2,393	12
13	35	LEASE EQUIP	Mgmt. Fee Contribution	360,999	12	2,856		120,000	949	13
14	10	NURSING WAGES	Mgmt. Fee Contribution	360,999	12	13,358	13,358	120,000	4,440	14
15	17	ADMINISTRATION WAGES	Mgmt. Fee Contribution	360,999	12	70,256	70,256	120,000	23,354	15
16	21	CLERICAL WAGES	Mgmt. Fee Contribution	360,999	12	99,484	99,484	120,000	33,070	16
17	6	MAINTENANCE WAGES	Mgmt. Fee Contribution	360,999	12	51,529	51,529	120,000	17,129	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 340,359	$ 234,627		$ 113,139	25

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Capaha Bank		X	Rental House Purchase	$707.84	3/3/04	63,500	59,571	3/3/09	6.0000	2,839	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$707.84		$ 63,500	$ 59,571			$ 2,839	14
15	TOTALS (line 9+line14)						$ 63,500	$ 59,571			$ 2,839	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	25,250	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	24,624	2
3. Under or (over) accrual (line 2 minus line 1).	$	(626)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	27,733	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	27,107	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	23,131	8
	2000	24,116	9
	2001	24,687	10
	2002	24,780	11
	2003	25,071	12

See Pg. 24

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mulberry Manor COUNTY Union

FACILITY IDPH LICENSE NUMBER 0025411

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE 618 833-5070 FAX #: 618 833-4993

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-20-03-681	S PT W 1/2 SE S of RD	$ 1,397.22	$ 1,397.22
2.	05-20-03-682	S PT W 1/2 SE S of RD	$ 22,051.70	$ 22,051.70
3.	05-20-03-683	S PT W 1/2 SE S of RD	$ 1,622.50	$ 1,622.50
4.	05-20-03-679	S20 T12 R1W W PT S PT W 1/2 SE S	$ 1,977.72	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,049.14	$ 25,071.42

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,715 B. General Construction Type: Exterior Brick/Block Frame Metal Stud Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Rental House

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Healthcare	76,230	1967	$ 8,687	1
2	Healthcare	45,000	1976	2,700	2
3	TOTALS	121,230		$ 11,387	3

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	46		1972		$ 172,058	$	30	$	$	$ 171,750	4
5	28		1975		151,678		27			151,678	5
6	6		1979		4,663		23			4,663	6
7			1979		40,400		15			40,400	7
8			1987		16,300		30	543	543	9,504	8
	Improvement Type**										
9	Gazebo			1986	2,561		5			2,561	9
10	Laundry Room			1990	18,146	576	31.5	454	(122)	8,317	10
11	Landscaping			1990	505	30	15	34	4	480	11
12	Central A/C			1990	9,323	312	10	312		9,323	12
13	Blue House Remodeling			1991	4,817	153	31.5	120	(33)	2,022	13
14	Blacktop Driveway			1992	3,260	192	15	163	(29)	2,775	14
15	New Roof			1992	8,055	475	15	403	(72)	6,862	15
16	Remodeled Living Room			1992	1,203	71	15	60	(11)	1,025	16
17	Seamless Gutters			1993	1,536	91	15	77	(14)	1,220	17
18	A/C & Heaters			1993	8,823	521	15	441	(80)	6,999	18
19	Dinning Room Improvements			1995	9,127	609	15	456	(153)	5,557	19
20	Bathroom, Carpet & Fencing			1995	4,428	295	15	295		2,507	20
21	Capet			1997	1,684		7	168	168	1,684	21
22	Smoking Room Addition			1997	46,392	1,189	39	1,160	(29)	8,373	22
23	Smoking Room Equipment			1998	952		7	95	95	952	23
24	A/C C Wing			1998	2,446	163	15	163		1,059	24
25	Kitchen Cabinets			1998	779		7	78	78	779	25
26	Office A/C			1998	1,059	71	15	71		461	26
27	Storage Building			1999	3,857	257	15	257		1,413	27
28	Water Garden			2001	2,922	195	15	195		609	28
29	A/C Compressor			2001	1,027	69	15	68	(1)	250	29
30	Fire Supression System			2003	1,716	80	15	114	34	635	30
31	Office Remodel			2003	8,543	399	15	570	171	3,161	31
32	A/C Laundry Room			2003	1,068	36	15	71	35	588	32
33	Furnace Blue House			2004	2,213	1,162	15	135	(1,027)	1,162	33
34	Stopper II Fire Alamr			2004	637	637	7	68	(569)	637	34
35	Vinyl Fence			2004	5,350	2,809	15	119	(2,690)	2,809	35
36	A/C Roof Mount			2004	2,473	1,299	15	110	(1,189)	1,299	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remodeling	1985	$ 1,867	$	15	$ 93	$ 93	$ 1,867	37
38	Remodel Bathrooms	1988	10,790		15	540	540	10,790	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 552,658	$ 11,691		$ 7,433	$ (4,258)	$ 466,171	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 7,827	$ 706	$ 1,185	$ 479	5-7	$ 5,775	71
72	Current Year Purchases	12,923	12,923	1,336	(11,587)	5-15	12,923	72
73	Fully Depreciated Assets	105,561		9,058	9,058	5-7	105,561	73
74								74
75	TOTALS	$ 126,311	$ 13,629	$ 11,579	$ (2,050)		$ 124,259	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	Ford Van 1993	1993	$ 25,942	$	$	$	5	$ 25,942	76
77	Healthcare	Ford Van 1997	1997	25,653				5	25,653	77
78	Healthcare	Ford Van 1999	1999	29,272	848	2,929	2,081	5	29,272	78
79										79
80	TOTALS			$ 80,867	$ 848	$ 2,929	$ 2,081		$ 80,867	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 771,223	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,941	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,227)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 671,297	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental	$ 67,775	$ 3,872	$ 3,872	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 67,775	$ 3,872	$ 3,872	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,801 Description: Misc. Medical Equipment $811; Telephone Equipment $990
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 44

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 86

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	1,173	2,222		3,395
4	Clinical Wages	(b)	2,373	4,513		6,886
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments		2,940	1,680		4,620
8	Nurse Aide Competency Tests					
9	TOTALS		$ 6,486	$ 8,415	$	$ 14,901
10	SUM OF line 9, col. 1 and 2	(e)	$ 14,901			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	14
2. From other facilities (f)	
TOTAL TRAINED	22

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Mulberry Manor # 0025411 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 858,408	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	649,305		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,296,124		8
9	Other(specify): See Pg 24	9,807		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,813,644	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	64,013		14
15	Leasehold Improvements, at Historical Cost	157,525		15
16	Equipment, at Historical Cost	208,317		16
17	Accumulated Depreciation (book methods)	(284,516)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 145,339	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,958,983	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30,170	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,584		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,014		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,733		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 121,501	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	59,969		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 59,969	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 181,470	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,777,513	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,958,983	$	48

***(See instructions.)**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,732,316	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,732,316	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	185,197	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(140,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 45,197	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,777,513	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,856,500	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,856,500	3
	B. Ancillary Revenue		
4	Day Care	741,616	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 741,616	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	19,259	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 22,459	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,977	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,977	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,638,552	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	538,644	31
32	Health Care	1,731,215	32
33	General Administration	524,093	33
	B. Capital Expense		
34	Ownership	490,122	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	169,281	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,453,355	40
41	**Income before Income Taxes (line 30 minus line 40)****	185,197	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 185,197	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,002	2,090	$ 41,783	$ 19.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,424	13,011	172,908	13.29	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	10,267	10,504	82,795	7.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,158	14,595	129,449	8.87	15
16	Dishwashers					16
17	Maintenance Workers	2,437	2,581	47,625	18.45	17
18	Housekeepers	6,476	6,919	60,439	8.74	18
19	Laundry					19
20	Administrator	2,000	2,080	102,000	49.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,891	3,011	33,850	11.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,058	8,380	114,696	13.69	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	56,964	58,745	491,017	8.36	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,677	121,916	$ 1,276,562 *	$ 10.47	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	140	$ 5,606	1-3	35
36	Medical Director	72	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	1,325	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	186	4,650	10a-3	43
44	Activity Consultant	4	336	11-3	44
45	Social Service Consultant	258	9,030	12-3	45
46	Other(specify) Dental	12	1,200	10-3	46
47	Psychologist	47	3,550	10a-3	47
48	Psychiatrist	28	2,800	10a-3	48
49	TOTAL (lines 35 - 48)	791	$ 35,697		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jo Ann Keller	Administrator	50	$ 102,304
Linda Isom	Admin. Sec.		26,327
Other Sec. Staff			6,464
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,095

B. Administrative - Other

Description	Amount
None	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
kel-Tech Mgmt Co.	Bookkeeping/ Mgmt Service	$ 120,000
Barnett & Levine	CPA Services	2,475
FMRG	Legal Services	1,091
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 123,566

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,624
Unemployment Compensation Insurance	16,199
FICA Taxes	95,488
Employee Health Insurance	33,093
Employee Meals	49
Illinois Municipal Retirement Fund (IMRF)*	
kel-Tech Allocation	24,799
Staff Meals	(49)
Employee Physicals	609
TOTAL (agree to Schedule V, line 22, col.8)	$ 235,812

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 53)	
See Detail Pg 24	5,955
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,955

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
kel-Tech Allocation	137
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 137

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mulberry Manor # 0025411 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 105 Line 12

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES No NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 169,281
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 49 Has any meal income been offset against related costs? None Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. Not Required of this facility.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Mulberry Manor, Inc.
Real Estate Taxes Analysis
2004

Sch.IX. Supplement, Question B

Tax Index #	Description	Tax Amount
05-20-03-681	Healthcare Related Property	$ 1,397.22
05-20-03-682	Healthcare Related Property	22,051.70
05-20-03-683	Healthcare Related Property	1,622.50
Total Healthcare Property		25,071.42
05-20-03-679	Currently Rental House	1,977.72
Total Other Property		1,977.72
Total Real Estate Taxes Paid By Facility		27,049.14
Pre Payment of Taxes By Seller At Purchase		(2,425.33)
Net R/E Taxes Paid By Facility		$ 24,623.81

Taxes Paid Out		
	Mulberry Manor Expense	$ 25,071.00
	Rental House Expense	1,978.00
Change in 2004 Accrual Payable 2005		2,483.00
Pre-Pmts Received from Property Seller		(2,425.00)
Net R/E Taxes Expense 2004		27,107.00
KT Allocation		527.00
Non-Care R/E Taxes		(1,978.00)
Sch. V, Line 33, Col. 8		$ 25,656.00

Mulberry Manor, Inc.
Analysis of Schedule XIX, F.
2004

Advertising		$ 1,274.00
Subscriptions		559.00
Membership Fees		455.00
MES of Illinois		778.00
Cable for Residents		93.00
Resident Acct. Bond		900.00
Interest		38.00
Help Wanted		970.00
IL State Police Background Checks		692.00
Post Office Box Rental		68.00
IL Corp. Annual Report		100.00
Guardianship Resident		1,085.00
kel-Tech Allocation		313.00
Vehicle Lic. Renewal		234.00
Contributions		2,015.00
Total		9,574.00
Less:		
	Advertising	1,274.00
	Cable TV Resident	92.00
	NFIB Membership	200.00
	Interest	38.00
	Contributions	2,015.00
Total		3,619.00
Net		$ 5,955.00

Mulberry Manor, Inc.
Reconciliation of Depreciation
2004

Sch. V, line 30, Col. 8		$ 30,172.00
Less:		
	kel-Tech Mgnt Allocation	(4,004.00)
Sch. XI. Line 82		$ 26,168.00

Mulberry Manor, Inc.
Analysis of Accounts Receivable Other
Sch. XV, Line 9
2004

DSP Training Reimbursable	$ 7,690.00
Staff & Resident Loans	799.00
Interest Receivable	1,318.00
Total	$ 9,807.00

Mulberry Manor, Inc.
Detail of Sch. XX, Line 14
2004

Rental House

Depreciation	Removed Sch. VI	$ 3,872.00
Interest	Removed Sch. VI	2,887.00
		$ 6,759.00

Mulberry Manor, Inc.
Sch. XVII, Line 43
Reconciliation of Tax to Book Income
2004

Adjusted Book Income		$ 185,197.00
Adjustment for Accrual Changes 2004		(7,496.00)
Adjustment For Non-Deductable Expenses:		
	Officer's Life Insurance	185.00
	Tax Penalties	1,614.00
Add (Deduct) Provision For Federal Income Taxes Payable (Refundable)		84,962.00
Taxable Income (Loss) Per Federal Income Tax Return		$ 264,462.00

Related Parties Schedule VII
Owners Compensation
Jan 1, 2004 - Dec 31, 2004

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Liberty House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	$ 142,235	$ 12,000	$ 12,000	$ 24,000			$ 6,000		$ 5,035	$ 43,200		$ 40,000
Denise Pippins	$ 114,648	26000	22431	66217								
Diana Alley	$ 88,105	12000	24000	9600	15301			13846	13358			
Jo Ann Keller	$ 138,304			12000	102304	24000						
James K. Keller	$ 26,725			12000	14725							
Jacob Alley	$ 50,294								50294			
Jake Alley	$ 34,718		30090	4428	200							
James A. Keller	$ 95,022		18500						65222		11300	
	$ 690,051	$ 50,000	$ 107,021	$ 128,245	$ 132,530	$ 24,000	$ 6,000	$ 13,846	$ 133,909	$ 43,200	$ 11,300	$ 40,000